(FILE 'HOME' ENTERED AT 15:33:09 ON 18 JUL 2005)

FILE 'MEDLINE, BIOSIS, EMBASE, CAPLUS' ENTERED AT 15:33:18 ON 18 JUL 2005

```
L1          1357 S INTRATHECAL CATHETER?
L2             0 S L1 AND ALZHEIMER?
L3             9 S L1 AND (NSAID OR ((ANTIINFLAMMATORY OR ANTI-INFLAMMATORY) (2W
L4             9 DUP REM L3 (0 DUPLICATES REMOVED)
L5          2831 S INTRATHECAL AND CATHETER
L6            48 S L5 AND (NSAID OR ANTIINFLAMMATORY OR ANTI-INFLAMMATORY)
L7            42 S L6 NOT L4
L8            39 DUP REM L7 (3 DUPLICATES REMOVED)
L9             2 S L5 AND ALZHEIMER?
L10            2 DUP REM L9 (0 DUPLICATES REMOVED)
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FILE 'STNGUIDE' ENTERED AT 15:44:47 ON 18 JUL 2005

10/049,327

L4 ANSWER 1 OF 9 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 2005:251051 BIOSIS
DN PREV200510040496
TI Analysis of interactions between serotonin and gabapentin or adenosine in the spinal cord of rats.
AU Yoon, Myung Ha [Reprint Author]; Choi, Jeong Il; Park, Heon Chang; Bae, Hong Beom; Jeong, Seong Wook; Jeong, Chang Young
CS Chonnam Natl Univ, Dept Anesthesiol and Pain Med, Sch Med, 8 Hakdong, Gwangju 501757, South Korea
mhyoon@chonnam.ac.kr
SO Pharmacology (Basel), (05) Vol. 74, No. 1, pp. 15-22.
CODEN: PHMGBN. ISSN: 0031-7012.
DT Article
LA English
ED Entered STN: 8 Jul 2005
Last Updated on STN: 8 Jul 2005
AB We evaluated the nature of the pharmacologic interaction after concurrent administration of 5-HT-gabapentin and 5-HT-adenosine at the spinal level. **Intrathecal catheters** were placed in the subarachnoid space of male Sprague-Dawley rats. Nociception was induced by subcutaneous injection of formalin solution (5%, 50 mu l) into the hind paw. A fixed dose analysis and an isobolographic analysis were used to determine the properties of interaction. Intrathecal 5-HT dose-dependently suppressed the flinching response during phase 1 of the formalin test, while neither gabapentin nor adenosine affected the phase-1 flinching response. All three intrathecal drugs attenuated the phase-2 flinching response in a dose-dependent manner. The intrathecal combination of 5-HT with a fixed dose of gabapentin or adenosine in phase 1 had little effect or increased the antinociception of 5-HT alone. Isobolographic analysis in phase 2 revealed an additive or a synergistic interaction after intrathecal delivery of 5-HT -gabapentin or 5-HT -adenosine mixture. Taken together, the combination of 5-HT with either gabapentin or adenosine may offer a potential remedy in the treatment of the facilitated state as well as acute pain in the spinal cord. Copyright (C) 2005 S. Karger AG, Basel.

L4 ANSWER 2 OF 9 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 2004:471750 BIOSIS
DN PREV200400466652
TI Preemptive effects of intrathecal cyclooxygenase inhibitor or nitric oxide synthase inhibitor on thermal hypersensitivity following peripheral nerve injury.
AU Lui, Ping-Wing [Reprint Author]; Lee, Chen-Hwa
CS Dept Anesthesiol, Chang Gung Mem Hosp, 5 Fushin St, Taoyuan, 333, Taiwan
pwlui@adm.cgmh.org.tw
SO Life Sciences, (October 8 2004) Vol. 75, No. 21, pp. 2527-2538. print.
ISSN: 0024-3205 (ISSN print).
DT Article
LA English
ED Entered STN: 9 Dec 2004
Last Updated on STN: 9 Dec 2004
AB The present study provides an important implication for the management of chronic neuropathic pain, focusing on prostaglandin (PG) and nitric oxide (NO) in the spinal cord. To determine if spinally administered cyclooxygenase (COX) inhibitor or nitric oxide synthase (NOS) inhibitor had preemptive analgesia on thermal hypersensitivity induced by chronic constrictive nerve injury, Sprague-Dawley rats were chronically implanted with an intrathecal (i.t.) catheter. The left sciatic nerve was loosely ligated with 2-mm polyethylene tubing to produce painful mononeuropathy. Animals received tenoxicam (7.5, 15 or 30 mumol/10 mul, i.t.), NS-398 (15 or 30 mumol), or L-NAME (30, 150 or 300 mumol) immediately before the nerve injury, followed by daily injection extending into the four postoperative days. The hindpaw was immersed into a hot (42degreeC, 44degreeC and 46degreeC) or cold (10degreeC) water bath. The paw immersion test revealed significant thermal hyperalgesia and allodynia 5 day after nerve injury in vehicle control animals. Tenoxicam (7.5, 15 or 30 mumol) or L-NAME (30, 150 or 300 mumol) dose-dependently attenuated

hyperalgesia and allodynia. Equimolar dose of NS-398 (15 or 30 mumol) also diminished these nociceptive behaviors. Higher dose of either drug primarily produced longer duration of inhibition. The inhibitory effect of tenoxicam (30 mumol) on hyperalgesia was more effective than that of an equimolar dose of NS-398 or L-NAME. These results demonstrated that intrathecally administered COX inhibitor or NOS inhibitor provides preemptive analgesia on thermal hypersensitivity following chronic constrictive nerve injury in rats.

L4 ANSWER 3 OF 9 BIOSIS on STN
AN 2004:235580 BIOSIS
DN PREV200400236138
TI Emergency treatment of life-threatening intrathecal methotrexate overdose.
AU Finkelstein, Yoram [Reprint Author]; Zevin, Shoshana; Heyd, Judith; Bentur, Yedidiah; Zigelman, Yehezkel; Hersch, Moshe
CS Department of Neurology, Shaare Zedek Medical Center, Jerusalem, 91031, Israel
yfinkel@md2.huji.ac.il
SO Neurotoxicology (Amsterdam), (March 2004) Vol. 25, No. 3, pp. 407-410. print.
CODEN: NRTXDN. ISSN: 0161-813X.
DT Article
LA English
ED Entered STN: 28 Apr 2004
Last Updated on STN: 28 Apr 2004
AB A male 34-year-old patient with aggressive diffuse malignant lymphoma was hospitalized for treatment. Because of high likelihood of CNS involvement, intrathecal methotrexate (MIX) 15 mg was administered with hydrocortisone 100 mg. Shortly after the intrathecal injection the patient became agitated, and complained of severe low back pain and 2 h later he became confused and developed generalized seizures. At this stage, it was realized that the dose contained 1200 mg of MTX (80-fold overdose). The patient developed ARDS and was comatose; he was intubated and transferred to ICU. The patient was immediately treated with intravenous leucovorin 1200 mg, and 15 mg every 6 h, thereafter, for 72 h. In addition, CSF exchange with warm normal saline was initiated via **intrathecal catheter**, and a total of 200 ml of CSF were replaced during 48 h. Finally, at the end of the exchange 2 mg of leucovorin with 2 mg of dexamethasone were administered intrathecally. MTX levels in CSF 7 h post-injection were 770 muM, and increased to 1250 muM 2 h later. Thereafter, the levels in CSF declined, and 48 h post-injection were 47 muM. The plasma levels of MTX 7 h post-injection were 10 muM, and declined to 0.7 muM at 68 h. The patient regained consciousness and underwent successful weaning from ventilator after tracheostomy. The highest reported intrathecal dose after which the patient survived was 625 mg. Due to the rarity of reported cases, there are no clear guidelines for treatment of massive intrathecal overdose. There is a controversy regarding the toxicity of intrathecal injection of leucovorin. We propose CSF exchange and intravenous leucovorin as the mainstay of treatment.

L4 ANSWER 4 OF 9 BIOSIS on STN
AN 2004:368245 BIOSIS
DN PREV200400367367
TI **Intrathecal catheterization** and solvents interfere with cortical somatosensory evoked potentials used in assessing nociception in awake rats.
AU Shi, Lin; Lebrun, Philippe; Camu, Frederic; Zizi, Martin [Reprint Author]
CS Dept PhysiolSch MedFac Med, Free Univ Brussels, 103 Laarbeeklaan, B-1090, Brussels, Belgium
martin.zizi@vub.ac.be
SO Anesthesia & Analgesia, (July 2004) Vol. 99, No. 1, pp. 159-165. print.
CODEN: AACRAT. ISSN: 0003-2999.
DT Article
LA English
ED Entered STN: 8 Sep 2004
Last Updated on STN: 8 Sep 2004

AB We assessed the objective measurement of central sensitization processes in the awake rat after subcutaneous formalin with cortical somatosensory evoked potentials (CSEPs). Cranial extradural electrodes and **intrathecal catheters** were implanted in adult male Wistar rats. After 7 days of recovery, CSEPs were induced by electrical stimuli at the tail and recorded before/after the injection of 50 muL of 2% formalin into the hindpaw of rats for 1 h. The drug and tested vehicles were delivered intrathecally 5 min before the injection of formalin. The peak-to-peak amplitude of the P1-N1 (the early positive-negative sequence pair of CSEPs) and the baseline-to-peak amplitude of the N2 (the late negative component of CSEPs) were analyzed. We found that the amplitudes of both signals increased (154.3% +/- 10.9% and 168.7% +/- 9.8%, respectively) from 10 min after formalin injection to the end of the 60-min test period. Pretreatment with intrathecal ketorolac dose-dependently prevented the increases induced by formalin in both measured variables. Moreover, the increases in P1-N1 and N2 were markedly attenuated either by intrathecal polyethylene-10 tubing or by the solvents used for injection, thus indicating the need for distinguishing an impaired nociceptive signal from antinociception when the effects of drugs are evaluated.

L4 ANSWER 5 OF 9 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 2004:20732 BIOSIS
DN PREV200400011622
TI Effects of Intrathecal Methylprednisolone on the Development of Neuropathic Pain and Spinal Glial Activation in a Rat Model.
AU Takeda, Kenji [Reprint Author]; Sawamura, Shigehito [Reprint Author]; Sekiyama, Hiroshi [Reprint Author]; Tamai, Hisayoshi [Reprint Author]; Hanaoka, Kazuo [Reprint Author]
CS Anesthesiology, Tokyo University Hospital, Bunkyo, Tokyo, Japan
SO Anesthesiology Abstracts of Scientific Papers Annual Meeting, (2003) No. 2003, pp. Abstract No. A-1084. http://www.asa-abstracts.com. cd-rom. Meeting Info.: 2003 Annual Meeting of the American Society of Anesthesiologists. San Francisco, CA, USA. October 11-15, 2003. American Society of Anesthesiologists.
DT Conference; (Meeting)
Conference; Abstract; (Meeting Abstract)
LA English
ED Entered STN: 24 Dec 2003
Last Updated on STN: 24 Dec 2003
AB Introduction: Few basic data are available regarding the efficacy or mechanisms of action of intrathecal corticosteroids in neuropathic pain. Recent studies have shown that spinal glial activation mediates the development and maintenance of pathological pain states (1). We investigated the effects of continuous intrathecal administration of methylprednisolone (MP) on the development of neuropathic pain and spinal glial activation responses in a rat model of spinal nerve ligation. Methods: Male Sprague-Dawley rats (150-200 gram) were anesthetized with isoflurane and the left L5 and L6 spinal nerves were tightly ligated. An **intrathecal catheter** was then inserted through the L4/5 interspace and connected to an osmotic pump implanted subcutaneously, which continuously delivered MP (80 mg/kg/day) or saline (n = 6 for each group). At 4 and 7 days postoperatively, mechanical allodynia and thermal hyperalgesia were quantified with tactile sensitivity to von Frey hairs and paw withdrawal latency to heat stimulus, respectively. Rats were then perfused with 4% paraformaldehyde and the lumbar spinal cord was removed. Forty micrometer-thick spinal sections were immunostained with antibody for glial fibrillary acidic protein (GFAP) to identify activated astrocytes. Indices of astrocytic activation in the dorsal horn were obtained from microscopic analysis of cell morphology, positive cell count and intensity of immunoreactivity. Data were compared between the MP and the saline groups using unpaired t-tests and p values less than 0.05 were considered significant. Results: Mechanical allodynia and thermal hyperalgesia observed in the saline group were significantly inhibited in the MP group (Figures). Remarkable astrocytic activation observed in the saline group was also significantly inhibited in the MP group. Discussions: Continuous intrathecal administration of MP prevented the development of neuropathic pain and spinal glial activation in a rat model

of spinal nerve ligation. We speculate that inhibition of spinal prostaglandin and/or cytokine production may be involved in these effects of MP. Furthermore, continuous administration of MP may be advantageous in order to avoid the interruptions of drug effects (2)..

L4 ANSWER 6 OF 9 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 2003:109391 BIOSIS
DN PREV200300109391
TI Spinal Prostaglandin Formation and Pain Perception Following Thoracotomy; a Role for Cyclooxygenase-2.
AU McCrory, Connail R. [Reprint Author]; Diviney, Dara D. [Reprint Author]; Moriarty, Jeanne M. [Reprint Author]; Luke, David A. [Reprint Author]; Fitzgerald, Desmond J. [Reprint Author]
CS Clinical Pharmacology, Royal College of Surgeons in Ireland, Dublin, Ireland
SO Anesthesiology Abstracts of Scientific Papers Annual Meeting, (2002) No. 2001, pp. Abstract No. A-797. http://www.asa-abstracts.com. cd-rom. Meeting Info.: 2001 Annual Meeting of the American Society of Anesthesiologists. New Orleans, LA, USA. October 13-17, 2001. American Society of Anesthesiologists Inc.
DT Conference; (Meeting)
Conference; Abstract; (Meeting Abstract)
LA English
ED Entered STN: 26 Feb 2003
Last Updated on STN: 26 Feb 2003
AB Prostaglandins facilitate processing of spinal nociceptive signals, which may explain the analgesic effects of non-steroidal antiinflammatory drugs (NSAIDs) following surgery. Surgery may induce cyclooxygenase (COX)-2 dependant prostaglandin generation in dorsal ganglia. Consequently COX-2 inhibitors may be particularly useful for postoperative analgesia. Thirty patients undergoing thoracotomy for adenocarcinoma were randomized to three groups receiving no NSAIDs, the non-selective COX inhibitor ibuprofen or the selective COX-2 inhibitor nimesulide as part of their analgesic regime in conjunction with repeat bolus intrathecal morphine delivered via an **intrathecal catheter**. Cerebrospinal fluid (CSF) was analysed preoperatively as control and on both day 1 and 2 postoperatively for 6-keto-prostaglandin(PG)F1alpha, the principle metabolite of prostacyclin. COX-1 and-2 activity was determined ex vivo by measuring serum thromboxane and endotoxin-induced PGE2 generation in whole blood. Pain was assessed by visual analogue scale (VAS), intrathecal morphine requirement and peak flow assessment. The VAS scale ranged from 0-10, and intrathecal morphine was administered in 0.5-1.0mg boluses depending upon VAS score, target VAS was 3 or less. CSF 6-keto-PGF1alpha increased following surgery, peaking at 48hrs, (from 32+-4.9 to 127+-29 pg/ml; $p<0.001$). The increase in CSF6-ketoPGF1alpha was inhibited by nimesulide, (49+-9.3 pg/ml; $p=0.002$vs untreated patients), but was unaffected by ibuprofen, (122+-35 pg/ml), which at the dose used had little effect on endotoxin-induced plasma PGE2 and so acted largely as a COX-1 inhibitor. Pain scores ($p<0.001$), intrathecal morphine requirement ($p=0.017$) and the fall in peak expiratory flow rate ($p<0.001$) were significantly lower in the nimesulide group. Post-thoracotomy pain and the increase in CSF prostaglandin levels were suppressed by a selective COX-2 inhibitor. Post-thoracotomy pain may be mediated by COX-2 dependent prostaglandin generation in the spinal cord. Selective COX-2 inhibition should be considered as part of the analgesic strategy after thoracotomy. .

L4 ANSWER 7 OF 9 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 2003:109472 BIOSIS
DN PREV200300109472
TI Salicylic Acid Enhances the Analgesic Effect of Dibucaine on Inflammatory Pain but Not Nociceptive Pain.
AU Kirihara, Yumiko [Reprint Author]; Saito, Yoji [Reprint Author]; Nakatani, Toshihiko [Reprint Author]; Hashimoto, Tatsuya [Reprint Author]; Sakura, Shinich [Reprint Author]
CS Dept. of Anesthesiology, Shimane Medical University, Izumo, Shimane, Japan
SO Anesthesiology Abstracts of Scientific Papers Annual Meeting, (2002) No. 2001, pp. Abstract No. A-878. http://www.asa-abstracts.com. cd-rom.

Meeting Info.: 2001 Annual Meeting of the American Society of Anesthesiologists. New Orleans, LA, USA. October 13-17, 2001. American Society of Anesthesiologists Inc.
DT Conference; (Meeting)
Conference; Abstract; (Meeting Abstract)
LA English
ED Entered STN: 26 Feb 2003
Last Updated on STN: 26 Feb 2003
AB Background: Postoperative pain is composed of several elements such as nociceptive pain and inflammatory pain. A combination of local anesthetics and non-steroid anti-inflammatory drugs (NSAIDs) produces good postoperative analgesia by affecting on those elements (1)(2). While NSAIDs are usually administered orally or rectally, spinal NSAIDs also produce analgesia on inflammatory pain (3). However, there has been little information about analgesic interaction of local anesthetics and NSAIDs at the spinal cord. This study is designed to evaluate the analgesic interaction of intrathecally coadministered dibucaine (D) and salicylic acid (S) on nociceptive pain and inflammatory pain. Methods: Male rats were implanted **intrathecal catheters** from L4-L5 with the approval of our animal research committee. D 0.2 apprx 5 mg/ml, S 3 apprx 15 mg/ml, D1 + S 3 mg/ml, D 3 + S 9 mg/ml, or normal saline (N) were intrathecally administered. To measure a withdrawal response to noxious thermal pain, tail flick (TF) test was carried out at 5, 10, 15, 20, 30, 45, 60 and 90 min after drug injection. TF latencies were converted to percent maximal possible effects (% MPEs). To measure a response to inflammatory pain, formalin test was performed. Formalin solution (2 %) was injected to rat's paw 5 minutes after drug injection. The number of flinches of the paw was counted with 5-min intervals for 60 min. Statistical differences were analyzed by repeated measure ANOVA followed by Sheff's test. Results: D increased % MPEs in the TF test and decreased flinches in the formalin test in dose-dependent fashion, although both S and N did not change % MPEs in the TF test. A high dose of S decreased flinches slightly. Coadministered S did not affect the % MPEs of D in the TF test (figure A). However, coadministered S decreased the number of flinches of D in second phase of the formalin test (figure B). Conclusions: Salicylic acid enhances the analgesic effect of dibucaine on the formalin test but not on the TF test at the spinal level.

L4 ANSWER 8 OF 9 CAPLUS COPYRIGHT 2005 ACS on STN
AN 2001:596504 CAPLUS
DN 136:469
TI The acute antihyperalgesic action of nonsteroidal, anti-inflammatory drugs and release of spinal prostaglandin E2 is mediated by the inhibition of constitutive spinal cyclooxygenase-2 (COX-2) but not COX-1
AU Yaksh, Tony L.; Dirig, David M.; Conway, Charles M.; Svensson, Camilla; Luo, Z. David; Isakson, Peter C.
CS Department of Anesthesiology, University of California, San Diego, La Jolla, CA, 92093-0818, USA
SO Journal of Neuroscience (2001), 21(16), 5847-5853
CODEN: JNRSDS; ISSN: 0270-6474
PB Society for Neuroscience
DT Journal
LA English
AB Western blots show the constitutive expression of COX-1 and COX-2 in the rat spinal dorsal and ventral horns and in the dorsal root ganglia. Using selective inhibitors of cyclooxygenase (COX) isoenzymes, we show that in rats with chronic indwelling **intrathecal catheters** the acute thermal hyperalgesia evoked by the spinal delivery of substance P (SP; 20 nmol) or NMDA (2 nmol) and the thermal hyperalgesia induced by the injection of carrageenan into the paw are suppressed by intrathecal and systemic COX-2 inhibitors. The intrathecal effects are dose-dependent and stereospecific. In contrast, a COX-1 inhibitor given systemically, but not spinally, reduced carrageenan-evoked thermal hyperalgesia but had no effect by any route with spinal SP hyperalgesia. Using intrathecal loop dialysis catheters, we showed that intrathecal SP would enhance the release of prostaglandin E2 (PGE2). This intrathecally evoked release of spinal PGE2 was diminished by systemic delivery of nonspecific COX and COX-2-selective inhibitors, but not a COX-1-selective inhibitor. Given at

systemic doses that block SP- and carrageenan-evoked hyperalgesia, COX-2, but not COX-1, inhibitors reduced spinal SP-evoked PGE2 release. Thus, constitutive spinal COX-2, but not COX-1, is an important contributor to the acute antihyperalgesic effects of spinal as well as systemic COX-2 inhibitors.

RE.CNT 54 THERE ARE 54 CITED REFERENCES AVAILABLE FOR THIS RECORD
ALL CITATIONS AVAILABLE IN THE RE FORMAT

L4 ANSWER 9 OF 9 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 1999:468915 BIOSIS
DN PREV199900468915
TI Lack of neurotoxicity from intrathecal indomethacin (INM) in a chronic rat preparation.
AU Guevara, U. [Reprint author]; Aldrete, J. A.; DeLille, R. [Reprint author]; Gutierrez, B. [Reprint author]; Tamariz, O. [Reprint author]; Sagoya, J. [Reprint author]
CS Pain Research Laboratory, National Institute of Nutrition, Mexico City, Mexico
SO Regional Anesthesia and Pain Medicine, (May-June, 1999) Vol. 24, No. 3 SUPPL., pp. 72. print.
Meeting Info.: Annual Meeting of the American Society of Regional Anesthesia. Philadelphia, Pennsylvania, USA. May 6-9, 1999. American Society of Regional Anesthesia.
ISSN: 1098-7339.
DT Conference; (Meeting)
Conference; Abstract; (Meeting Abstract)
Conference; (Meeting Poster)
LA English
ED Entered STN: 9 Nov 1999
Last Updated on STN: 9 Nov 1999

L8 ANSWER 1 OF 39 CAPLUS COPYRIGHT 2005 ACS on STN
AN 2005:524980 CAPLUS
DN 143:53501
TI Use of PACAP antibodies, antagonists and PACAP RNA interference for inhibition of PACAP receptor activity, and treatment of overactive bladder and pelvic floor pain syndrome
IN Vizzard, Margaret A.; Zvara, Peter
PA University of Vermont and State Agricultural College, USA
SO U.S. Pat. Appl. Publ., 41 pp.
CODEN: USXXCO
DT Patent
LA English
FAN.CNT 1

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
US 2005129687	A1	20050616	US 2004-980985	20041103
PRAI US 2003-516862P	P	20031103		

AB The present invention relates to the use of inhibitors of PACAP receptor activity for the treatment of pelvic floor pain syndrome and overactive bladder. In one embodiment of the invention the inhibitor of PACAP receptor activity is a monoclonal antibody. In certain embodiments of the invention the inhibitor of PACAP receptor activity is a PACAP antagonist. In preferred embodiments of the invention the PACAP antagonist is selected from the list comprised of: PACAP6-38, PACAP6-27 or a mixture thereof. In one aspect of the invention the inhibitor of PACAP receptor activity is an isolated short RNAs that has sequence corresponding to PACAP receptor mRNA and mediate RNA interference by directing cleavage of the PACAP receptor mRNA, or inactivate the PACAP receptor gene by transcriptional silencing. Therapeutic action of PACAP6-38 was demonstrated on rat models of overactive bladder and pelvic floor pain syndrome.

L8 ANSWER 2 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2005144032 EMBASE
TI The National Institute of Clinical Excellence (NICE) guidelines for caesarean sections: Implications for the anaesthetist.
AU Wee M.Y.K.; Brown H.; Reynolds F.
CS M.Y.K. Wee, Department of Anaesthesia, Poole Hospital NHS Trust, Longfleet Road, Poole, Dorset BH 15 2JB, United Kingdom. m.wee@virgin.net
SO International Journal of Obstetric Anesthesia, (2005) Vol. 14, No. 2, pp. 147-158.
Refs: 119
ISSN: 0959-289X CODEN: IOANER
CY United Kingdom
DT Journal; General Review
FS 010 Obstetrics and Gynecology
017 Public Health, Social Medicine and Epidemiology
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20050421
Last Updated on STN: 20050421
AB Introduction: The bodies involved; Background; Aims of the guidelines; Evidence and grading of recommendations. Summary of Recommendations Affecting Anaesthetic Practice: Provision of information and consent. Classification of urgency of caesarean section. Planned caesarean section. Factors in intrapartum care affecting likelihood of caesarean section. Factors with no influence on caesarean section rates: Epidural analgesia; Eating in labour. Procedural aspects of caesarean section: Decision-to-delivery interval for emergency caesarean section; Pre-operative testing and preparation for caesarean section; Urinary catheterisation at caesarean section. Aspects of anaesthesia for caesarean section: Antacids and antiemetics; General versus regional anaesthesia for caesarean section; Converting epidural analgesia to anaesthesia for caesarean section; Place of induction and monitoring during caesarean section; Procedures to avoid hypotension; Failed

intubation. Surgical techniques for caesarean section of relevance to the anaesthetist: Use of uterotonics; Uterine exteriorisation; Use of antibiotics; Thromboprophylaxis for caesarean section. Care of the baby born by caesarean section. Care of the woman after caesarean section: High dependency and intensive care admission; Routine monitoring after caesarean section. Pain management after caesarean section: **Intrathecal** and epidural analgesia; Patient controlled analgesia (PCA) and non-steroidal **anti-inflammatory** analgesics; Other local anaesthetic techniques. Post partum care: Early eating and drinking after caesarean section; Urinary **catheter** removal after caesarean section; Length of hospital stay. Conclusion.

L8 ANSWER 3 OF 39 EMBASE
on STN
AN 2005094322 EMBASE
TI Acute and chronic pain after thoracotomies.
AU Senturk M.
CS Dr. M. Senturk, Department of Anesthesiology, Istanbul University, Medical Faculty of Istanbul, Capa 34018 Istanbul, Turkey. senturkm@istanbul.edu.tr
SO Current Opinion in Anaesthesiology, (2005) Vol. 18, No. 1, pp. 1-4.
Refs: 29
ISSN: 0952-7907 CODEN: COAEE2
CY United Kingdom
DT Journal; General Review
FS 008 Neurology and Neurosurgery
009 Surgery
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
ED Entered STN: 20050310
Last Updated on STN: 20050310
DATA NOT AVAILABLE FOR THIS ACCESSION NUMBER

L8 ANSWER 4 OF 39 CAPLUS
AN 2004:473339 CAPLUS
DN 141:33787
TI A small interfering oligonucleotide duplex inhibiting COX-II isoenzyme without affecting COX-I expression, and methods for treating COX-II associated diseases
IN Shemesh, Mordechai; Shore, Laurence; Stram, Yehuda; Michaeli, Shulamit; Breitbart, Haim
PA Kimron Veterinary Institute, Israel; Bar-Llan University
SO U.S. Pat. Appl. Publ., 30 pp.
CODEN: USXXCO
DT Patent
LA English
FAN.CNT 1

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
PI US 2004110698	A1	20040610	US 2002-315218	20021210
PRAI US 2002-315218		20021210		

AB The present invention relates to oligonucleotides which can be used to treat COX-II (cyclooxygenase inducible isoenzyme)-associated diseases such as, diabetes, stroke and Alzheimer's disease. The present inventor provided, for the first time, a small interfering oligonucleotide duplex (siRNA), which enables to inhibit COX-II protein production without affecting COX-I expression. A small interfering duplex oligonucleotide comprising a 15 to 30 base pair sequence being at least 90 % identical to a contiguous nucleic acid sequence of COX-II, as determined using the GCG BestFit software of the Wisconsin sequence anal. package, utilizing the Smith and Waterman algorithm, where gap weight equals 50, length weight equals 3, average match equals 10 and average mismatch equals -9.

L8 ANSWER 5 OF 39 EMBASE
on STN
AN 2004227874 EMBASE

TI Moderate-to-severe pain after knee arthroscopy is relieved by intraarticular saline: A randomized controlled trial.
AU Rosseland L.A.; Helgesen K.G.; Breivik H.; Stubhaug A.
CS Dr. L.A. Rosseland, Rikshospitalet University Hospital, Department of Anesthesia, 0027 Oslo, Norway. l.a.rosseland@klinmed.uio.no
SO Anesthesia and Analgesia, (2004) Vol. 98, No. 6, pp. 1546-1551.
Refs: 19
ISSN: 0003-2999 CODEN: AACRAT
CY United States
DT Journal; Article
FS 008 Neurology and Neurosurgery
024 Anesthesiology
030 Pharmacology
037 Drug Literature Index
LA English
SL English
ED Entered STN: 20040628
Last Updated on STN: 20040628
AB We have previously studied intraarticular (IA) analgesics compared with saline 10 mL in 2 randomized clinical trials. The patients who were given IA saline experienced rapid pain relief. Hypothetically, saline may produce a local analgesic effect by cooling or by diluting IA algogenic substances. This randomized double-blind study compared the analgesic effect of IA saline 10 mL with saline 1 mL, which should be a pure placebo. A soft **catheter** was left IA in 79 patients. We included 60 patients who developed moderate-to-severe pain within 1 h after knee arthroscopy under general anesthesia. A randomized, double-blind controlled comparison of IA saline 10 mL with saline 1 mL followed. Outcome measures were pain intensity, pain relief, and analgesic consumption. Within 1 h pain intensity decreased in both groups from approximately 50 to approximately 27 on a 0-100 mm visual analog scale. Pain intensity remained low and other pain outcome measures were similar during the 36-h observation period. The patients experienced equally good pain relief after IA injection of saline 10 mL and 1 mL. Our finding of a major placebo effect may have implications for the interpretation of previously published placebo-controlled IA analgesia studies.

L8 ANSWER 6 OF 39 EMBASE
on STN
AN 2004493096 EMBASE
TI Interventional procedures for cancer pain management: When are they indicated?.
AU De Leon-Casasola O.A.
CS Dr. O.A. De Leon-Casasola, Pain Medicine, Roswell Park Cancer Institute, Elm and Cavlton, Buffalo, NY 14263, United States. Oscar-deleon@roswellpark.org
SO Cancer Investigation, (2004) Vol. 22, No. 4, pp. 630-642.
Refs: 64
ISSN: 0735-7907 CODEN: CINVD7
CY United States
DT Journal; General Review
FS 016 Cancer
027 Biophysics, Bioengineering and Medical Instrumentation
036 Health Policy, Economics and Management
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20041202
Last Updated on STN: 20041202
AB Non-invasive pharmacological management of patients with cancer related pain has resulted in pain control in 90-95% of the patients. Thus, 5-10% of patients still experience inadequate pain control despite aggressive combined pharmacological therapy. Moreover, patients may not tolerate an aggressive program of titration of medications and fail this approach because of side effects. In these patients interventional techniques have been very useful. This article discusses the alternative therapies, as

well as the pitfalls in implementing these therapies, to achieve the highest possible success while minimizing potential complications and side effects.

L8 ANSWER 7 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2005032347 EMBASE
TI The evolving role of interventional pain management in oncology.
AU Sloan P.A.
CS Dr. P.A. Sloan, Department of Anesthesiology, University of Kentucky Hospital, 800 Rose Street, Lexington, KY 40536, United States. PaulSloan1956@yahoo.com
SO Journal of Supportive Oncology, (2004) Vol. 2, No. 6, pp. 491-503. Refs: 49
ISSN: 1544-6794 CODEN: JSOOBY
CY United States
DT Journal; General Review
FS 008 Neurology and Neurosurgery
016 Cancer
036 Health Policy, Economics and Management
037 Drug Literature Index
038 Adverse Reactions Titles
039 Pharmacy
LA English
SL English
ED Entered STN: 20050127
Last Updated on STN: 20050127
AB Patients with cancer frequently experience chronic pain, especially in the terminal phases of illness. Fortunately, most patients (90%) can achieve good pain relief using standard and adjuvant analgesics. For those patients who experience severe pain resistant to traditional analgesic therapies, interventional pain management techniques often provide welcome pain relief. The use of neurolytic substances has been used for many decades but has found a niche in the treatment of pain related to abdominal and pelvic cancers. Simple, percutaneous injections of alcohol or phenol can provide much needed pain relief for patients with pancreatic, colon, or gynecologic cancers. The percutaneous placement of catheters for the chronic infusion of spinal analgesics can provide pain relief for virtually any part of the body. Internal or external infusion pumps can be well managed at home, improving quality of life. The physician treating the pain should be aware of these and other interventional pain management techniques to provide alternative therapies to patients with refractory cancer pain. .COPYRGT. 2004 Elsevier Inc. All rights reserved.

L8 ANSWER 8 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2004115418 EMBASE
TI Current management of pediatric postoperative pain.
AU Kokki H.
CS Dr. H. Kokki, Department of Pharmacology, University of Kuopio, PO Box 1627, FIN 70211, Kuopio, Finland. hannu.kokki@kuh.fi
SO Expert Review of Neurotherapeutics, (2004) Vol. 4, No. 2, pp. 295-306. Refs: 125
ISSN: 1473-7175 CODEN: ERNXAR
CY United Kingdom
DT Journal; General Review
FS 007 Pediatrics and Pediatric Surgery
024 Anesthesiology
030 Pharmacology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20040412
Last Updated on STN: 20040412
AB Pain is a common complaint in children after surgery. Four out of five children require analgesia even after minor surgery, and after more

extensive surgery, significant postoperative pain may last for weeks. Severe pain during, and after surgery may aggravate long-lasting negative effects to the body and mind. In order to prevent harmful effects, all children should be provided with effective analgesia. Pain management should be safe and easy to administer. Postoperative pain management in children has improved substantially during the last 5 years. Recent trials indicate that children may undergo major surgery with minimal untoward effects when effective proactive pain management is provided. This review will focus on new clinical strategies on pain management in children. Since most pediatric surgery is performed as a day-case or short-stay basic recommendations for parental guidance and pain management after discharge are also presented.

L8 ANSWER 9 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2005001818 EMBASE
TI Neural injury after interventions for chronic pain.
AU Brewer R.P.
CS Dr. R.P. Brewer, Department of Neurology, LSUHSC-Shreveport, 150 Kings Highway, Shreveport, LA 71103-3932, United States. brewe019@mc.duke.edu
SO Seminars in Pain Medicine, (2004) Vol. 2, No. 4, pp. 244-251.
Refs: 88
ISSN: 1537-5897 CODEN: SPMEC5
PUI S 1537-5897(04)00085-0
CY United States
DT Journal; General Review
FS 005 General Pathology and Pathological Anatomy
008 Neurology and Neurosurgery
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20050113
Last Updated on STN: 20050113
AB Interventions for chronic pain are important in the diagnosis and treatment of many disorders causing chronic pain and suffering. Injury to the peripheral or central nervous system is a rare but important cause of morbidity and mortality following chronic pain interventions. Mechanisms of neural injury include neural ischemia, compression from hematoma, abscess, granuloma, and neurotoxicity. This review will highlight the pathophysiology of neural injuries, review the literature regarding specific injuries and mechanisms, and suggest practical guidelines for injury prevention. .COPYRGT. 2004 Elsevier Inc. All rights reserved.

L8 ANSWER 10 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2004504311 EMBASE
TI An overview of interventional spinal techniques.
AU Deer T.R.
CS Dr. T.R. Deer, Department of Anesthesiology, The West Virginia Univ. Sch. of Med., The Center For Pain Relief Inc., 400 Court Street, Charleston, WV 25301, United States. DocTDeer@aol.com
SO Seminars in Pain Medicine, (2004) Vol. 2, No. 3, pp. 154-166.
Refs: 72
ISSN: 1537-5897 CODEN: SPMEC5
PUI S 1537-5897(04)00075-8
CY United States
DT Journal; General Review
FS 008 Neurology and Neurosurgery
033 Orthopedic Surgery
036 Health Policy, Economics and Management
037 Drug Literature Index
038 Adverse Reactions Titles
039 Pharmacy
LA English
SL English
ED Entered STN: 20041209
Last Updated on STN: 20041209

AB The use of interventional techniques to treat spine-related pain syndromes is becoming more common in the United States and abroad. This growth is related to several factors, including improved patient awareness, education of referring physicians, improved training of interventional pain specialists, and advances in equipment and technology. The spectrum of interventional techniques ranges from simple trigger-point injections to implantation of sophisticated devices to modulate the nervous system. The challenges of treating these patients involve the need to make a diagnosis, the choice of an appropriate technique, and the performance of that technique in an acceptable manner. The pain specialist should also be able to recognize the complications of these techniques and make good decisions in responding to adverse outcomes. Several chapters would be required to comprehensively cover interventional techniques for the treatment of pain of spinal origin. It is the objective of this article to cover the most commonly performed procedures in regard to the patient selection, procedure selection, techniques, and complication management.

L8 ANSWER 11 OF 39 EMBASE
on STN
AN 2003506850 EMBASE
TI Anaesthesia, surgery, and challenges in postoperative recovery.
AU Kehlet H.; Dahl J.B.
CS H. Kehlet, Dept. of Surgical Gastroenterology, Hvidovre University Hospital, DK-2650 Hvidovre, Denmark. henrik.kehlet@hh.hosp.dk
SO Lancet, (6 Dec 2003) Vol. 362, No. 9399, pp. 1921-1928.
Refs: 117
ISSN: 0140-6736 CODEN: LANCAO
CY United Kingdom
DT Journal; General Review
FS 008 Neurology and Neurosurgery
009 Surgery
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20040116
Last Updated on STN: 20040116
AB Surgical injury can be followed by pain, nausea, vomiting and ileus, stress-induced catabolism, impaired pulmonary function, increased cardiac demands, and risk of thromboembolism. These problems can lead to complications, need for treatment in hospital, postoperative fatigue, and delayed convalescence. Development of safe and short-acting anaesthetics, improved pain relief by early intervention with multimodal analgesia, and stress reduction by regional anaesthetic techniques, β-blockade, or glucocorticoids have provided important possibilities for enhanced recovery. When these techniques are combined with a change in perioperative care a pronounced enhancement of recovery and decrease in hospital stay can be achieved, even in major operations. The anaesthetist has an important role in facilitating early postoperative recovery by provision of minimally-invasive anaesthesia and pain relief, and by collaborating with surgeons, surgical nurses, and physiotherapists to reduce risk and pain.

L8 ANSWER 12 OF 39 EMBASE
on STN
AN 2003423715 EMBASE
TI Spinal delivery of analgesics in experimental models of pain and analgesia.
AU Fairbanks C.A.
CS C.A. Fairbanks, Department of Pharmaceutics, University of Minnesota, 9-177 Weaver-Densford Hall, 308 Harvard St. SE, Minneapolis, MN 55455, United States. carfair@med.umn.edu
SO Advanced Drug Delivery Reviews, (15 Aug 2003) Vol. 55, No. 8, pp. 1007-1041.
Refs: 337
ISSN: 0169-409X CODEN: ADDREP

CY Netherlands
DT Journal; General Review
FS 008 Neurology and Neurosurgery
030 Pharmacology
037 Drug Literature Index
038 Adverse Reactions Titles
039 Pharmacy
LA English
SL English
ED Entered STN: 20031106
Last Updated on STN: 20031106
AB Systemic administration of analgesics can lead to serious adverse side effects compromising therapeutic benefit in some patients. Information coding pain transmits along an afferent neuronal network, the first synapses of which reside principally in the spinal cord. Delivery of compounds to spinal cord, the intended site of action for some analgesics, is potentially a more efficient and precise method for inhibiting the pain signal. Activation of specific proteins that reside in spinal neuronal membranes can result in hyperpolarization of secondary neurons, which can prevent transmission of the pain signal. This is one of the mechanisms by which opioids induce analgesia. The spinal cord is enriched in such molecular targets, the activation of which inhibit the transmission of the pain signal early in the afferent neuronal network. This review describes the pre-clinical models that enable new target discovery and development of novel analgesics for site-directed pain management.

L8 ANSWER 13 OF 39 MEDLINE on STN
AN 2003478063 MEDLINE
DN PubMed ID: 14556140
TI Transverse myelitis associated with Acinetobacter baumanii **intrathecal** pump **catheter**-related infection.
CM Comment in: Reg Anesth Pain Med. 2004 Sep-Oct;29(5):503-4; author reply 504-5. PubMed ID: 15372398
AU Ubogu Eroboghene E; Lindenberg Judah R; Werz Mary Ann
CS Case Western Reserve University School of Medicine, Cleveland, OH 44106, USA.
SO Regional anesthesia and pain medicine, (2003 Sep-Oct) 28 (5) 470-4. Journal code: 9804508. ISSN: 1098-7339.
CY United States
DT (CASE REPORTS)
Journal; Article; (JOURNAL ARTICLE)
LA English
FS Priority Journals
EM 200403
ED Entered STN: 20031015
Last Updated on STN: 20040312
Entered Medline: 20040311
AB OBJECTIVE: To describe a late neurologic complication of **intrathecal** pump implantation and show the methods used for the diagnosis and successful treatment of transverse myelitis in this setting. CASE REPORT: A 32-year-old man with a chronic abdominal pain syndrome presented with right lower-extremity numbness 2 months after the placement of an **intrathecal** morphine pump. This progressed to bilateral lower extremity and ascending sensory loss to T12-L1 dermatome, significant lower-extremity weakness, constipation with overflow incontinence, and detrusor instability causing urinary incontinence in discrete episodes over the following 2 months consistent with a myelopathy. Magnetic resonance imaging (MRI) of the thoracic spine and cerebrospinal fluid (CSF) analysis were consistent with transverse myelitis. The **intrathecal** pump was removed and an Acinetobacter baumanii **catheter**-tip infection was diagnosed. Clinical course improved with the co-administration of intravenous corticosteroids and antibiotics, with significant clinical improvement within 30 days. CONCLUSIONS: Clinicians should recognize transverse myelitis as a possible late complication of **intrathecal** pump placement. Early medical intervention and removal of the **intrathecal** pump may be necessary to prevent irreversible spinal cord damage and may support good

recovery.

L8 ANSWER 14 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2004309318 EMBASE
TI Continuous spinal anaesthesia: What's new and what's not.
AU Bevacqua B.K.
CS Dr. B.K. Bevacqua, Univ. of Wisconsin School of Med., William S. Middleton VAMC 112A, Anesthesiology Service, 2500 Overlook Terrace, Madison, WI 53705, United States. brian.bevacqua2@med.va.gov
SO Best Practice and Research in Clinical Anaesthesiology, (2003) Vol. 17, No. 3, pp. 393-406.
Refs: 60
ISSN: 1521-6896 CODEN: BPRCD8
PUI S 1521-6896(02)00117-9
CY United Kingdom
DT Journal; General Review
FS 024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20040805
Last Updated on STN: 20040805
AB Continuous spinal anaesthesia combines the advantages of single-dose spinal anaesthesia, rapid onset and a high degree of success, with those of a continuous technique. The introduction of micro-catheters invigorated interest in the technique and allowed its expansion to additional populations and surgical procedures. However, multiple cases of cauda equina syndrome associated with micro-catheters and (primarily) hyperbaric lidocaine solution led to withdrawal of micro-catheters from the US market, casting doubt over the safety of continuous spinal anaesthesia as a whole. A decade after these events it is possible to look back at the experience with continuous spinal anaesthesia for operative anaesthesia and postoperative analgesia and to compare it with the available alternatives. From this perspective, continuous spinal anaesthesia remains a useful and safe technique. Future research should focus on the comparison of continuous spinal anaesthesia with the combined spinal/epidural technique and the use of newer spinal agents. .COPYRGT. 2003 Published by Elsevier Ltd.

L8 ANSWER 15 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2004063565 EMBASE
TI Regional Anesthesia for Cesarean Section.
AU Riley E.T.
CS Dr. E.T. Riley, Department of Anesthesia, Stanford University, Stanford, CA 94305, United States. edriley@stanford.edu
SO Techniques in Regional Anesthesia and Pain Management, (2003) Vol. 7, No. 4, pp. 204-212.
Refs: 47
ISSN: 1084-208X CODEN: TRAMFV
CY United States
DT Journal; General Review
FS 010 Obstetrics and Gynecology
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
039 Pharmacy
LA English
SL English
ED Entered STN: 20040226
Last Updated on STN: 20040226
AB Spinal or epidural local anesthetics are common and very reliable ways to provide anesthesia for cesarean section. Regional anesthesia avoids many of the maternal risks associated with general anesthesia. Spinal anesthesia is a good choice for elective cesarean section. In laboring women, epidural analgesia can be readily converted to epidural anesthesia.

The combined spinal epidural technique is useful when surgery may be prolonged and in patients who may not tolerate standard doses of **intrathecal** local anesthetic. This article reviews some technical aspects to consider when performing regional anesthesia for cesarean section. It offers suggested protocols for each of these techniques. Lastly, it discusses two common clinical situations: the inadequate epidural anesthetic and the conversion of labor epidural analgesia to operative epidural anesthesia.

L8 ANSWER 16 OF 39 EMBASE
on STN
AN 2003365879 EMBASE
TI Common pitfalls in anesthesia for noncardiac thoracic surgery.
AU Anagnostou J.M.
CS Dr. J.M. Anagnostou, Department of Anesthesia, Indiana Univ. School of Medicine, 302 Felser Hall, 1120 South Drive, Indianapolis, IN 46202-5114, United States. jonathan_anagnostou@anesthesia.iupui.edu
SO Seminars in Cardiothoracic and Vascular Anesthesia, (2003) Vol. 7, No. 2, pp. 189-203.
Refs: 102
ISSN: 1089-2532 CODEN: SCVAFI
CY United States
DT Journal; General Review
FS 015 Chest Diseases, Thoracic Surgery and Tuberculosis
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20031002
Last Updated on STN: 20031002
AB Over the past few decades, major surgical procedures involving the thorax have become commonplace at most larger medical facilities. Advances in perioperative care have allowed surgeons to perform increasingly complex procedures. These procedures are being performed on more seriously ill patients who are at increased risk for significant complications. Recent advances should help the anesthesiologist avoid some of the pitfalls in managing these complex patients. Preoperative assessment aids in the identification of patients at highest risk for intraoperative and postoperative events. Particular attention is given to myasthenia gravis, as thymectomy is among the most common surgical procedures that are performed in these patients. Aggressive pain control techniques, including neuraxial opioids and patient-controlled analgesia, where appropriate, not only improve patient comfort but can improve postoperative pulmonary function. Advances in techniques for providing one-lung ventilation allow the anesthesiologist more options to individualize management for each clinical scenario. Careful fluid management may help to minimize the risk of postoperative pulmonary complications. A basic understanding of video-assisted thoracic surgery should help the anesthesiologist provide optimal surgical conditions and perioperative care. Recent advances demand a greater role for the anesthesiologist if the best outcomes are to be achieved in patients undergoing thoracic procedures.

L8 ANSWER 17 OF 39 MEDLINE on STN
AN 2003459256 MEDLINE
DN PubMed ID: 12951230
TI Antinociceptive potency of **intrathecal** morphine in the rat tail flick test: a comparative study using acute lumbar **catheter** in rats with or without a chronic atlanto-occipital **catheter**.
AU Prado Wiliam A
CS Department of Pharmacology, Faculty of Medicine of Ribeirao Preto, University of Sao Paulo, Av. Bandeirantes 3900, 14049-900, Ribeirao Preto, SP, Brazil.. wadprado@fmrp.usp.br
SO Journal of neuroscience methods, (2003 Oct 15) 129 (1) 33-9.
Journal code: 7905558. ISSN: 0165-0270.
CY Netherlands

DT Journal; Article; (JOURNAL ARTICLE)
LA English
FS Priority Journals
EM 200310
ED Entered STN: 20031003
Last Updated on STN: 20031028
Entered Medline: 20031027
AB Chronic spinal catheterization via an atlanto-occipital puncture (CAO) has been widely used to study the effects of drugs on spinal nociceptive mechanisms, but this method is associated with spinal cord damage that may change the efficacy of spinally injected analgesics. Using a slight modification of the method of Storkson et al. (J. Neurosci. Methods 65 (1996) 167), the rat spinal cord was acutely catheterized via a lumbar puncture (AL) and the potency of morphine-induced antinociception in the tail flick test was comparatively studied in animals with or without a CAO **catheter**. The opiate potency via an AL **catheter** (AD50; 95% confidence limits) was significantly more intense in rats without (0.29 microg; 0.19-0.47) than in rats with a CAO **catheter** (1.1 microg; 0.87-1.47) and stronger than via a CAO **catheter** (8.2 microg; 4.6-14.4). The potency of morphine via a CAO **catheter** was significantly improved in indomethacin-pretreated rats (1 mg/kg, i.p., twice a day for 5 days), thus indicating that inflammatory changes produced by a CAO **catheter** are at least in part the reason for the lower efficacy of the opiate. The use of an AL **catheter** minimizes such spinal changes and permits acute experimental protocols in which more than one spinal injection is necessary.

L8 ANSWER 18 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2002420329 EMBASE
TI Neuraxial medication delivery: The development and maturity of a concept for treating chronic pain of spinal origin.
AU Prager J.P.; Straus B.; Saal J.; Slosar P.; Turk D.; Wetzel F.T.; Andersson G.B.J.; Weinstein J.
CS Dr. J.P. Prager, 100 UCLA Medical Plaza, Los Angeles, CA 90095, United States. paindoc@UCLA.edu
SO Spine, (15 Nov 2002) Vol. 27, No. 22, pp. 2593-2606.
Refs: 67
ISSN: 0362-2436 CODEN: SPINDD
CY United States
DT Journal; Conference Article
FS 008 Neurology and Neurosurgery
027 Biophysics, Bioengineering and Medical Instrumentation
037 Drug Literature Index
038 Adverse Reactions Titles
039 Pharmacy
LA English
SL English
ED Entered STN: 20021205
Last Updated on STN: 20021205
AB Study Design. A literature review and synthesis were performed. Objective. To summarize the history, use, and innovation related to neuraxial drug delivery for the treatment of intractable back pain. Summary of Background Data. The discovery of opiold receptors in the early 1970s provided a rational basis for the delivery of opioid drugs intraspinally. Epidural or **intrathecal** infusions deliver drugs directly to opioid receptors, limit systemic exposure, and by decreasing the opioid dosage required for pain relief, generally reduce side effects. The benefits of short-term spinal analgesia led to investigation of longer-term continuous subarachnoid opioid infusions for the management of both cancer pain and noncancer pain, such as that of spinal origin. Methods. Results. Unique features of this article include an updated pain continuum, updated indications for **intrathecal** therapy, a detailed comparison of trial techniques, a detailed comparison of the advantages of different types of pumps, a synopsis of troubleshooting for inadequate efficacy, and an updated statement regarding **intrathecal** pumps and radiologic procedures, including MRI scanning. Some challenges remain. Large-scale well-controlled studies

could answer some perplexing questions regarding efficacy in patients with noncancer or neuropathic pain. Patient selection criteria undoubtedly will be refined and validated as more patients are treated. In addition, further investigation of specifically targeted medications or drug combinations for intraspinal use could increase efficacy, reduce side effects, and expand indications. Conclusions. Intraspinal medication delivery has become an effective technique for control of intractable pain in appropriately selected patients seen by spine surgeons.

L8 ANSWER 19 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2002366230 EMBASE
TI Comparison between repeat bolus **intrathecal** morphine and an epidurally delivered bupivacaine and fentanyl combination in the management of post-thoracotomy pain with or without cyclooxygenase inhibition.
AU McCrory C.; Diviney D.; Moriarty J.; Luke D.; Fitzgerald D.
CS Dr. C. McCrory, Department of Thoracic Surgery, St. James Hospital, Royal College of Surgeons, Dublin, Ireland
SO Journal of Cardiothoracic and Vascular Anesthesia, (2002) Vol. 16, No. 5, pp. 607-611.
Refs: 20
ISSN: 1053-0770 CODEN: JCVAEK
CY United States
DT Journal; Article
FS 008 Neurology and Neurosurgery
024 Anesthesiology
037 Drug Literature Index
LA English
SL English
ED Entered STN: 20021031
Last Updated on STN: 20021031
AB Objective: To compare the analgesic efficacy of a traditional epidurally delivered bupivacaine/fentanyl combination with a repeat bolus **intrathecal** morphine technique in the management of post-thoracotomy pain and to assess further the effect of cyclooxygenase (COX) inhibition on both modalities. Design: Prospective, randomized, blinded study. Setting: University teaching hospital. Participants: Patients having thoracic surgery. Interventions: Epidural and **intrathecal** catheters were inserted. Blood and urine samples were collected for analysis. COX-1 and COX-2 inhibition with ibuprofen and nimesulide (COX-2 selective) was instituted. Measurements and Main Results: Pain was assessed at rest and coughing by visual analog scale. Peak expiratory flow rate, patient satisfaction rating, sedation score, analgesic requirements, and preoperative and postoperative urinary creatinine levels were measured. The spinal and nimesulide combination showed the lowest pain scores ($p < 0.001$), least reduction in peak expiratory flow rate ($p < 0.001$), and highest patient satisfaction rating ($p = 0.02$). COX inhibition did not affect analgesic requirements in the epidural group or increase urinary creatinine in any group. Conclusion: The **intrathecal** morphine and nimesulide combination offered significantly better analgesia than any other combination studied. The efficacious interaction between opioids and nonsteroidal **anti-inflammatory** drugs may be COX-2 mediated.

L8 ANSWER 20 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2004309353 EMBASE
TI Anaesthesia for minimally invasive cardiac surgery.
AU Ganapathy S.
CS S. Ganapathy, Department of Anesthesia, London Health Sciences Centre, University of Western Ontario, London, Ont. N6A 5A5, Canada
SO Best Practice and Research in Clinical Anaesthesiology, (2002) Vol. 16, No. 1, pp. 63-80.
Refs: 71
ISSN: 1521-6896 CODEN: BPRCD8
PUI S 1521-6896(01)90208-3

CY United Kingdom
DT Journal; General Review
FS 018 Cardiovascular Diseases and Cardiovascular Surgery
024 Anesthesiology
030 Pharmacology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 20040805
Last Updated on STN: 20040805
AB Minimally invasive cardiac surgery is used for both extracardiac and intracardiac procedures. Extracardiac procedures, such as coronary artery bypass grafting, are often performed on a beating heart. Intracardiac procedures are done with the aid of cardiopulmonary bypass. The surgery is performed via a minithoracotomy or a ministernotomy. Thoracoscopic video-assisted surgery, often with robotic assistance, necessitates prolonged one-lung ventilation to optimize exposure. Port-access surgery will require appropriate positioning of various catheters to establish cardiopulmonary bypass. Adequate flow during cardiopulmonary bypass may require suction augmentation of venous return and may increase the risk of air emboli. Limited exposure of the heart during surgery poses challenges with management of arrhythmia, haemostasis, myocardial protection and de-airing at the end of surgery. Patient selection is important to avoid intra-operative and post-operative complications. Prolonged single-lung ventilation, incomplete revascularization in hybrid procedures, and limited access for rapid intervention pose challenges with patient management. Conversion to sternotomy that may be required occasionally and extension of portals over several dermatomal segments mandate a versatile analgesic technique. .COPYRGT. 2002 Elsevier Science Ltd.

L8 ANSWER 21 OF 39 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 2003:109645 BIOSIS
DN PREV200300109645
TI Prophylaxis of Postoperative Pain by Balanced Intraoperative Analgesia.
AU Meissner, Winfried [Reprint Author]; Eberitsch, Juergen [Reprint Author]
CS Clinic of Anesthesiology, Friedrich Schiller University, Jena, Germany
SO Anesthesiology Abstracts of Scientific Papers Annual Meeting, (2002) No. 2000, pp. Abstract No. 950. http://www.asa-abstracts.com. cd-rom. Meeting Info.: 2000 Annual Meeting of the American Society of Anesthesiologists. San Francisco, CA, USA. October 16-18, 2000. American Society of Anesthesiologists Inc.
DT Conference; (Meeting)
Conference; Abstract; (Meeting Abstract)
LA English
ED Entered STN: 26 Feb 2003
Last Updated on STN: 26 Feb 2003
AB Background. While experimental data strongly support the concept of reducing postoperative pain by intraoperative interventions, clinical studies remain conflicting 1). The present trial was designed to study the influence of different balanced pre-incisional analgesia regimens on postoperative pain and analgesic requirements. Methods. After IRB approval, 150 patients undergoing elective hip replacement were randomly assigned to the groups general anesthesia (GA), spinal anesthesia with bupivacaine (SpA), additional local anesthetic skin infiltration (SpA-Inf), additional intramuscular 1 mg/kg diclofenac (SpA+D), additional **intrathecal** 0.001 mg/kg morphine (SpA+M), and spinal anesthesia with all interventions together (SpA+M+D+Inf). Postoperative pain therapy was delivered by 0.25% bupivacaine bolus injections via spinal **catheter** in all groups. Outcome parameters were time until the first demand of an analgesic bolus, mean cumulative number of bolus injections and mean pain intensity measured on the 101-step visual analog scale. Statistical analysis was performed using the Kruskal Wallis H-test. Results. Time until first analgesic demand was 0.3, 5.1, 5.2, 6.5, 10.7, and 12.9 hours for the groups GA, SpA, SpA+Inf, SpA+D, SpA+M, and SpA+M+D+Inf, respectively. The results for number of bolus injections were 6, 3.8, 4.5, 2.5, 1.8, and 0.8. The mean pain intensity was 12.6,

12.2, 12, 8.6, 9.3, and 5.3 at the 101-step VAS (Fig.). Groups differed significantly (p=0.001) in all three parameters. Discussion. Patients with pre-incisional analgesic management, consisting of spinal blockade by bupivacain/morphine and a peripheral antinociception by local anesthetics and **NSAID**, showed the best, patients after general anesthesia the worst postoperative pain control. Although a preemptive mechanism (long-term prevention of nociceptive sensitization) can not certainly be proven by this study design, the results demonstrate the powerful prophylactic effects of multimodal intraoperative analgesic management for postoperative pain.

L8 ANSWER 22 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 2001102421 EMBASE
TI Management of postdural puncture headache.
AU Choi P.T.-L.
CS Dr. P.T.-L. Choi, Department of Anesthesia, McMaster University, 1200 Main Street West, Hamilton, Ont. L8N 3Z5, Canada. choip@mcmaster.ca
SO Techniques in Regional Anesthesia and Pain Management, (2001) Vol. 5, No. 1, pp. 41-45.
Refs: 54
ISSN: 1084-208X CODEN: TRAMFV
CY United States
DT Journal; General Review
FS 010 Obstetrics and Gynecology
024 Anesthesiology
037 Drug Literature Index
LA English
SL English
ED Entered STN: 20010329
Last Updated on STN: 20010329
AB Postdural puncture headache (PDPH), a complication of regional anesthesia, is not infrequently seen in parturients because of their inherent risk from young age and female gender. With spinal anesthesia, the risk of PDPH is mainly dependent on the size and type of needle and can be reduced with the use of small-gauge, pencilpoint spinal needles. For unintentional dural puncture with epidural needles, a prophylactic epidural blood patch can reduce the risk of PDPH. Other potentially efficacious maneuvers include insertion of an **intrathecal catheter** and avoidance of second-stage pushing. Treatment of PDPH includes the use of caffeine or an epidural blood patch. Other pharmacologic interventions (eg, theophylline, sumatriptan, adrenocorticotropic hormone) and epidural administration of saline or dextran 40 await further investigation. The evidence for these interventions is discussed in this review. Copyright .COPYRGT. 2001 by W.B. Saunders Company.

L8 ANSWER 23 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 1999185792 EMBASE
TI Outcome and complications of epidural analgesia in patients with chronic cancer pain [2] (multiple letters).
AU Mercadante S.; Smitt P.S.; Tsafka A.; Vecht C.
CS S. Mercadante, SAMOT, Palermo and Pain Therapy Section, Dept. of Anesthesia/Intensive Care, Palermo, Italy
SO Cancer, (1 Jun 1999) Vol. 85, No. 11, pp. 2492-2494.
ISSN: 0008-543X CODEN: CANCAR
CY United States
DT Journal; Letter
FS 016 Cancer
024 Anesthesiology
037 Drug Literature Index
LA English
ED Entered STN: 19990617
Last Updated on STN: 19990617
DATA NOT AVAILABLE FOR THIS ACCESSION NUMBER

L8 ANSWER 24 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED.

on STN
AN 1999225791 EMBASE
TI Post-thoracotomy spirometric lung function: The effect of analgesia. A review.
AU Richardson J.; Sabanathan S.; Shah R.
CS J. Richardson, Department of Anaesthetics, Bradford Royal Infirmary, Bradford BD9 6RJ, United Kingdom
SO Journal of Cardiovascular Surgery, (1999) Vol. 40, No. 3, pp. 445-456. Refs: 85
ISSN: 0021-9509 CODEN: JCVSA2
CY Italy
DT Journal; Article
FS 008 Neurology and Neurosurgery
015 Chest Diseases, Thoracic Surgery and Tuberculosis
018 Cardiovascular Diseases and Cardiovascular Surgery
024 Anesthesiology
030 Pharmacology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 19990715
Last Updated on STN: 19990715
AB Background. The effects of postthoracotomy pain management on pulmonary function has been assessed. Methods. All English language publications involving prospective, randomised, controlled studies of patients undergoing postero-lateral thoracotomy incisions where perioperative spirometry had been studied were included. The mean postoperative percentage preservation of preoperative lung function was recorded or determined for each analgesic regimen. Results. 55 studies were reviewed with a total of 1762 patients. The most effective analgesic method in terms of preservation of spirometric function was paravertebral analgesia, patients having approximately 75% of their preoperative values in the first 48 hours after surgery. Most other techniques e.g. intercostal nerve blocks, epidural local anaesthetics or local anaesthetic-opiate combinations produced approximately a 55% preservation by 48 hours. Interpleural analgesia was the least effective, with a mean of 35% preservation by 48 hours, less even than TENS or cryoanalgesia. Conclusions. A thoracotomy potentially produces a marked reduction in postoperative pulmonary function and the choice of pain management has major implications. Attenuation of postthoracotomy pulmonary dysfunction by effective analgesia should be provided for all patients undergoing chest surgery. Simply providing effective analgesia on its own without regard to pulmonary function is inadequate. Spirometric monitoring should be standard in all thoracic units and is essential for objective comparisons of the efficacy of different methods of pain management.

L8 ANSWER 25 OF 39 EMBASE
on STN
AN 1999258206 EMBASE
TI **Intrathecal** infusion of bupivacaine with or without buprenorphine relieved intractable pain in three patients with vertebral compression fractures caused by osteoporosis.
AU Dahm P.O.; Nitescu P.V.; Appelgren L.K.; Curelaru I.D.
CS I.D. Curelaru, Dept. of Anesthesiol and Pain Sec., Sahlgrenska University Hospital, c/o Dr. Petre Nitescu, S-413 45 Gothenburg, Sweden
SO Regional Anesthesia and Pain Medicine, (1999) Vol. 24, No. 4, pp. 352-357. Refs: 16
ISSN: 0146-521X CODEN: RAPMFX
CY United States
DT Journal; Article
FS 024 Anesthesiology
030 Pharmacology
033 Orthopedic Surgery
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English

ED Entered STN: 19990805
Last Updated on STN: 19990805
AB Background and Objectives. At present, there is no reliable method of relieving 'refractory' pain in patients with compression fractures of the vertebral bodies caused by osteoporosis. We explored the possibility of relieving this type of pain by **intrathecal** (IT) infusion of bupivacaine with or without buprenorphine. Methods. An 18-g nylon IT **catheter** was inserted via a lumbar interspace with its tip positioned at the level of the fractured vertebra from which the maximal pain originated. Bupivacaine (2.3755.0 mg/mL) with (n = 1) or without (n = 2) buprenorphine (0.015 mg/mL) was infused through the IT **catheter** from an external electronic pump. The infusion began in the operating room at a basic rate of 0.1-0.2 mL/h, with optional bolus doses (0.1 mL, 1-4 times/h) via patient controlled analgesia. The daily dose of IT bupivacaine was adjusted to provide satisfactory pain relief [visual analogue scores (VAS) = 0-2 on a scale ol 0-10]. Results. Satisfactory pain relief was obtained with daily doses of IT bupivacaine ranging from 10 to 70 (mean .simeq.25) mg and buprenorphine from 0.02 to 0.2 (mean = 0.15) mg. The duration of IT treatment was 37, 387, and 407 days, respectively. Two patients terminated the IT treatment when it was no longer needed. Treatment was discontinued in the third patient because of death caused by irreversible heart failure. The 2 surviving patients were still free of pain 1,074 and 1,476 days after termination of the IT treatment. No severe complications occurred. Conclusions. Continuous **intrathecal** infusion of bupivacaine, with or without buprenorphine, appeared to be an effective method for the long- term treatment (months to >1 year) of 'refractory' pain from vertebral compression fractures, in this small group of patients.

L8 ANSWER 26 OF 39 MEDLINE on STN DUPLICATE 1
AN 1999349808 MEDLINE
DN PubMed ID: 10422945
TI Spinal antinociceptive effect of epidural nonsteroidal **antiinflammatory** drugs on nitric oxide-induced hyperalgesia in rats.
AU Masue T; Dohi S; Asano T; Shimonaka H
CS Department of Anesthesiology and Critical Care Medicine, Gifu University School of Medicine, Gifu City, Japan.
SO Anesthesiology, (1999 Jul) 91 (1) 198-206.
Journal code: 1300217. ISSN: 0003-3022.
CY United States
DT Journal; Article; (JOURNAL ARTICLE)
LA English
FS Abridged Index Medicus Journals; Priority Journals
EM 199908
ED Entered STN: 19990816
Last Updated on STN: 19990816
Entered Medline: 19990805
AB BACKGROUND: Nonsteroidal **antiinflammatory** drugs (NSAIDs) suppress various hyperalgesia perhaps via inhibition of cyclooxygenase activity at the spinal cord. The present study aimed to examine whether epidural application of NSAIDs affects hyperalgesia induced by nitric oxide. METHODS: The authors studied the antinociceptive effects of epidurally administered NSAIDs in rats with a chronically in-dwelling epidural **catheter** by three hyperalgesic models, including nitric oxide-induced hyperalgesia by nitroglycerin (10 microg) or l-arginine (100 microg), and the biphasic response in the formalin test. RESULTS: Epidural, but not systemic, nitroglycerin induced hyperalgesia that was completely blocked by methylene blue but not by N(omega)-nitro-L-arginine methyl ester (L-NAME). Epidural l-arginine, but not d-arginine, also induced hyperalgesia that was completely blocked by L-NAME. Epidural S(+)ibuprofen (100-1,000 microg) suppressed the nitroglycerin- and l-arginine-induced thermal hyperalgesia and also the second phase response in the formalin test. Neither systemic S(+)ibuprofen nor epidural R(-)ibuprofen suppressed the hyperalgesia Epidural indomethacin (10-100 microg) or diclofenac (10-1,000 microg) dose-dependently suppressed nitroglycerin-induced thermal hyperalgesia The order of potency for this suppression (ID50 in microg) was indomethacin = didofenac > S(+)ibuprofen

>> R(-)ibuprofen. CONCLUSIONS: The antinociceptive action of epidurally administered NSAIDs could be the result of suppression of spinal sensitization, perhaps induced with nitric oxide in the spinal cord. The ID50 values for epidural indomethacin, diclofenac, and S(+)ibuprofen were about 10 times higher than those reported in other studies for **intrathecal** NSAIDs in hyperalgesia models. (Key words: Cyclooxygenase inhibitors; NO donor; NO precursor; optical isomers; neuroplasticity.)

L8 ANSWER 27 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 1999336120 EMBASE
TI Cancer pain assessment and management: A survey.
AU Guptill W.E.; Carr D.B.
CS Dr. D.B. Carr, Department of Anesthesiology, New England Medical Center, Box 298, 750 Washington Street, Boston, MA 02111, United States. dcarr02@emerald.tufts.edu
SO Journal of Back and Musculoskeletal Rehabilitation, (1999) Vol. 12, No. 2, pp. 89-99.
Refs: 77
ISSN: 1053-8127 CODEN: JBMRFK
CY Netherlands
DT Journal; General Review
FS 016 Cancer
030 Pharmacology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 19991017
Last Updated on STN: 19991017
AB Cancer has a profound impact upon public health throughout the world due to its prevalence and devastating morbidity and mortality. For this reason, in 1980 the World Health Organization began an effort to codify prevailing approaches to cancer pain relief and to encourage implementation of these methods as health policy throughout the world. This review will summarize subsequent progress in assessing cancer pain and treating it by means of systemic and intraspinal pharmacologic management as well as nonpharmacologic interventions. Important elements of the initial pain evaluation include a detailed history, physical examination, psychosocial assessment and, when appropriate, a diagnostic plan to detect the cause of new or escalating pain. Moreover, clinicians treating cancer patients should recognize common cancer pain syndromes. Systemic pharmacologic management, the cornerstone of cancer pain management, must be individualized. The three major classes of drugs used today in the treatment of cancer pain, non-steroidal **anti-inflammatory** drugs (NSAIDs), opioids, and adjuvants will be discussed. The WHO three-step ladder to guide cancer pain treatment will be reviewed. The discussion will then turn to neuroaxial pharmacologic management in the treatment of refractory pain resistant to systemic drugs. Factors to consider in deciding whether to begin spinal opioid therapy will be described. Finally, nonpharmacologic management of cancer pain will be surveyed, ranging from psychosocial modalities to more invasive therapies.

L8 ANSWER 28 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 97188029 EMBASE
DN 1997188029
TI Cancer pain.
AU Drourr N.R.; Bajwa Z.H.; Warfield C.A.
CS Dr. C.A. Warfield, Beth Israel Hospital, Dept of Anesthesiol.-Pain Management, 330 Brookline Ave, Boston, MA 02215, United States
SO Seminars in Anesthesia, (1997) Vol. 16, No. 2, pp. 105-111.
Refs: 12
ISSN: 0277-0326 CODEN: SEANDW
CY United States
DT Journal; General Review

FS 008 Neurology and Neurosurgery
016 Cancer
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
ED Entered STN: 970710
Last Updated on STN: 970710
DATA NOT AVAILABLE FOR THIS ACCESSION NUMBER

L8 ANSWER 29 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 96246378 EMBASE
DN 1996246378
TI [The neurotoxicity of intrathecally administered agents].
NEUROTOXICITE DES AGENTS ADMINISTRES PAR VOIE INTRATHECALE.
AU Malinovsky J.M.; Pinaud M.
CS Service d'Anesthesie, Reanimation Chirurgicale, Hotel-Dieu,44035 Nantes Cedex 01, France
SO Annales Francaises d'Anesthesie et de Reanimation, (1996) Vol. 15, No. 5, pp. 647-658.
ISSN: 0750-7658 CODEN: AFAREO
CY France
DT Journal; General Review
FS 024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA French
SL French; English
ED Entered STN: 961001
Last Updated on STN: 961001
AB Spinal anaesthetics can induce histopathologic lesions and regional haemodynamic alterations in the spinal cord. There are numerous causes of neurologic lesions, including direct trauma of the spinal cord and nerve roots during puncture or **catheter** insertion, compromised spinal cord perfusion and direct neurotoxic effect. Histopathologic lesions are localized either in meninges (meningitis or arachnoiditis) or in neuraxis (myelitis or axonal degeneration). Neurotoxicity can result from decrease in neuronal blood supply, elicited by high concentrations of the solutions, long duration exposure of local anaesthetics, and the use of adjuvants. They have been implicated in the occurrence of cauda equina syndrome after continuous spinal anaesthesia using hyperbaric solution of lidocaine and tetracaine given through small diameter catheters. Selective spinal analgesia is induced by spinal opioids without motor blockade except for meperidine. Complications occurred in patients after high doses of morphine, which were related to one of its metabolites, morphine-3-glucuronide. Preservative-free opioid solutions are to be preferred for spinal anaesthesia. There is no report of neurotoxicity neither in animal studies, nor in humans, using spinal clonidine. In order to reduce the incidence of neurotoxicity, some safety rules should be followed. The lowest efficient dose of local anaesthetics must be given. Incomplete blockade should not necessarily lead to a reinjection. Large volume of hyperbaric lidocaine or repeated injections of such solutions must be avoided as well as preservative-containing solutions. The administration of new compounds by the spinal route must be supported by data of spinal neuropharmacology and the lack of neurotoxicity must have been previously checked with animal studies.

L8 ANSWER 30 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 96050080 EMBASE
DN 1996050080
TI Does pre-incisional thoracic extradural block combined with diclofenac reduce postoperative pain after abdominal hysterectomy.
AU Espinet A.; Henderson D.J.; Faccenda K.A.; Morrison L.M.M.
CS Department of Anaesthetics, St John's Hospital, Howden Road West,Livingston EH54 6PP, United Kingdom
SO British Journal of Anaesthesia, (1996) Vol. 76, No. 2, pp. 209-213.

ISSN: 0007-0912 CODEN: BJANAD
CY United Kingdom
DT Journal; Article
FS 009 Surgery
010 Obstetrics and Gynecology
024 Anesthesiology
037 Drug Literature Index
LA English
SL English
ED Entered STN: 960226
Last Updated on STN: 960226
AB In a double-blind, randomized study, we investigated 40 patients undergoing abdominal hysterectomy; patients received 0.5% plain bupivacaine 20 ml via a low thoracic extradural **catheter** and a diclofenac suppository (100mg), either 30min before incision (group 1) or 30 min after incision (group 2). All patients received a standard general anaesthetic and no opioid was used before or during operation. Postoperative analgesic requirements were measured using a patient-controlled analgesia (PCA) system. Pain was assessed using a visual analogue scale (VAS) and a verbal pain score (VPS) on movement up to 48 h after operation. There was no significant difference in the time to first request for morphine but consumption of morphine was significantly greater in group 1 at all times except 24h. There were no significant differences in VAS and VPS pain scores, although both scores were consistently higher in group 1. Patient satisfaction with the quality of analgesia, at 24h, demonstrated no significant difference between the two groups. The combination of extradural block and diclofenac suppository given before operation did not appear to produce a clinically effective pre-emptive analgesic effect.

L8 ANSWER 31 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 96014064 EMBASE
DN 1996014064
TI [Postoperative analgesia for spinal surgery].
ANALGESIE APRES CHIRURGIE DU RACHIS CHEZ L'ADULTE ET L'ADOLESCENT.
AU Bernard J.M.; Surbled M.; Lagarde D.; Trennec A.
CS Dept. d'Anesth.-Reanimation Chirurg., Hotel-Dieu,44035 Nantes Cedex, France
SO Cahiers d'Anesthesiologie, (1995) Vol. 43, No. 6, pp. 557-564.
ISSN: 0007-9685 CODEN: CAANBU
CY France
DT Journal; Article
FS 009 Surgery
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA French
SL French; English
ED Entered STN: 960206
Last Updated on STN: 960206
AB Postoperative pain after spinal surgeries is highly dependent on the number of vertebrae included in the operation and on its invasiveness, opposing two extremes, discectomies and cyphoscoliosis corrections. Opiates by intravenous route remain the reference, either continuously given in predetermined doses, or better using a patient-controlled device. Nonsteroidal and steroidal **anti-inflammatory** drugs are widely popular for medical approach of sciatalgia and it is quite logical to use them for reducing, even to suppress, opiates after spinal surgeries. Supported by many studies, spinal administration of analgesics (opiates, α2-agonists, corticosteroids) may be of interest in pain treatment of spinal surgeries. In order to prolong locoregional analgesia, a **catheter** may be inserted into epidural space by caudal route or surgically, before skin closure. Morphine is the most popular agent in this indication. Also, epidural clonidine results in excellent pain relief, but is associated with hypotension and marked sedation. In discectomy, injection of dexamethasone into the operative field has been proposed. Whatever the technique used, early diagnosis of

neurological complications of spinal surgery should be not ruled out by postoperative analgesia.

L8 ANSWER 32 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 95348011 EMBASE
DN 1995348011
TI Postoperative regional anaesthesia and analgesia.
AU Chrubasik S.; Chrubasik J.
CS Department of Internal Medicine 1, University of Heidelberg, Bergheimerstrasse 58,Heidelberg 69115, Germany
SO Current Opinion in Anaesthesiology, (1995) Vol. 8, No. 5, pp. 426-434. ISSN: 0952-7907 CODEN: COAEE2
CY United Kingdom
DT Journal; General Review
FS 009 Surgery
024 Anesthesiology
036 Health Policy, Economics and Management
037 Drug Literature Index
LA English
SL English
ED Entered STN: 951212
Last Updated on STN: 951212
AB Regional analgesia is being used with more confidence as a result of better appreciation of the risks and how to avoid them. Refinements to epidural opioid anaesthesia continue to be explored, including the use of continuous infusions rather than intermittent injections, and patient-controlled anaesthesia instead of nurse-adjusted dosing. Is there an optimal dose of an optimal opioid for epidural use and how much can the dose of opioid be reduced? What influence does the site of the **catheter** tip or use of adjuvants, such as local anaesthetics or α2-adrenergic agents have on the required dose and effectiveness of the opioid? Intrapleural, paravertebral, intercostal, and other nerve blocks remain the province of the enthusiastic expert, but have demonstrable uses. The effectiveness of pre-emptive analgesia continues to be explored, so far with inconsistent effects that are still poorly explained, as does intra-articular analgesia with opioids. If acute pain services are to attract the funding they need, they must justify it in terms of shorter hospital stay. The inclusion of regional techniques as part of balanced analgesia with opioids and non-steroidal **anti-inflammatory** drugs has shown promise if implemented as part of a multimodal approach to optimize general postoperative care, accelerate the return of gastrointestinal function, and hasten the mobilization of the patient.

L8 ANSWER 33 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 95330993 EMBASE
DN 1995330993
TI Safe and effective post-operative pain relief: Introduction and continuous quality-improvement of comprehensive post-operative pain management programmes.
AU Breivik H.; Hogstrom H.; Niemi G.; Stalder B.; Hofer S.; Fjellstad B.; Haugtomt H.; Thomson D.
CS Department of Anaesthesiology, Rikshospitalet, University of Oslo,N-0027 Oslo 1, Norway
SO Bailliere's Clinical Anaesthesiology, (1995) Vol. 9, No. 3, pp. 423-460. ISSN: 0950-3501 CODEN: BCANE2
CY United Kingdom
DT Journal; General Review
FS 008 Neurology and Neurosurgery
009 Surgery
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 951128

Last Updated on STN: 951128

AB Planning and implementing a comprehensive, hospital-wide post-operative pain management programme in two university hospitals started in 1992 with emphasis on patient safety and implementing patient-controlled intravenous morphine analgesia and epidural analgesia with a low dose bupivacaine, fentanyl and adrenaline analgesic mixture on ordinary wards as focus for improving quality of post-operative pain management. A major educational programme for all personnel involved in the care of surgical patients aimed at improving understanding of post-operative pain, the consequences of unrelieved pain and increased general knowledge of pain relieving drugs and methods. Gradual, ward-by-ward introduction of PCA and epidural analgesia, with individual follow-up of nurses and patients by the specially assigned anaesthesiologist and nurse, selection of electromechanically very safe pain pumps, standardized prescription and monitoring regimen, has resulted in good to excellent patient satisfaction in 90% of 5749 patients. Side effects reduced quality of pain relief or caused early discontinuation of PCA and epidural analgesia in 25% of patients during the early phase of the programme, later 10-15%. Nausea, dizziness, sedation, confusion, pruritus, and urinary retention were the most frequent adverse effects during PCA. These were infrequent or mild during epidural analgesia, but epidural **catheter**-problems occurred in 15-20% of patients. Epidural **catheter** problems have improved, but continue to cause failure or premature discontinuation in 10-15% of epidural analgesia patients. No serious complications with permanent adverse outcome occurred. Four patients had potentially serious respiratory depression in 2922 PCA patients during 11 380 PCA-patient-days due to human error, three potentially serious complications in 2827 epidural patients during 14870 epidural-patient-days, all were discovered early and treated successfully. These results demonstrate clearly that the infrastructure, the educational and quality assurance programmes of our post-operative pain management concept, are both effective and safe. The economic cost of equipment, medication, and wages for the personnel assigned to the programme are modest when we consider that most surgical patients benefit from the comprehensive post-operative pain management programme. Although we have not attempted to document reductions in post-operative complications or in duration of post-operative course, it is plausible that there is an overall net saving in health care cost from the post-operative pain management programme.

L8 ANSWER 34 OF 39 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN

AN 1995:304172 BIOSIS

DN PREV199598318472

TI Long term treatment of intractable reflex sympathetic dystrophy with **intrathecal** morphine.

AU Becker, W. J. [Reprint author]; Ablett, D. P.; Haris, C. J.; Dold, O. N.

CS Dep. Clin. Neurosci., Calgary Gen. Hosp, M6-102, 841 Centre Ave. E, Calgary, AB T2 0A1, Canada

SO Canadian Journal of Neurological Sciences, (1995) Vol. 22, No. 2, pp. 153-159.
CODEN: CJNSA2. ISSN: 0317-1671.

DT Article

LA English

ED Entered STN: 11 Jul 1995
Last Updated on STN: 11 Jul 1995

AB Background: Some patients with reflex sympathetic dystrophy (RD) develop intractable symptoms unresponsive to conventional therapy. Recently, **intrathecal** morphine therapy has been used with some success in such patients. Methods: The clinical course of two patients with intractable reflex sympathetic dystrophy (RSD) is described. Both patients developed intractable leg pain, swelling and autonomic changes after a leg injury. Numerous medical treatments and surgical sympathectomies failed to provide long term relief. Results: Relatively satisfactory symptom control was achieved only with the use of long term **intrathecal** morphine therapy delivered by subcutaneously implanted infusion pumps. Exacerbations of the RSD continued to occur, at times in association with further leg trauma, but these could be controlled by a temporary escalation of the **intrathecal** morphine dose.

Complications of morphine therapy were relatively minor. A red rash appearing over the pump site was the first sign that a drug **catheter** break had occurred, necessitating surgical **catheter** revision. Conclusion: Long term **intrathecal** morphine therapy is a useful treatment option for patients with intractable severe RSD who have failed other therapies and remain markedly disabled.

L8 ANSWER 35 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 95100007 EMBASE
DN 1995100007
TI Outcomes of epidural morphine treatment in cancer pain: Nine years of clinical experience.
AU Samuelsson H.; Malmberg F.; Eriksson M.; Hedner T.
CS Pain Section, Anaesthesiology/Intensive Care Dept., Boras Hospital,S-501 82 Borg, Sweden
SO Journal of Pain and Symptom Management, (1995) Vol. 10, No. 2, pp. 105-112.
ISSN: 0885-3924 CODEN: JPSMEU
CY United States
DT Journal; Article
FS 008 Neurology and Neurosurgery
016 Cancer
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 950420
Last Updated on STN: 950420
AB The outcome of epidural morphine therapy is described in 146 consecutive cancer patients who were treated by a community hospital-based pain service. The routine procedure used a standard epidural **catheter** that was tunneled subcutaneously. One hundred and twenty-one patients improved and stayed on lifelong or chronic epidural opioids. Mean treatment time was 92 days (median, 47; range, 2-2040); 49% of the time was spent as outpatients. Twenty-five patients failed to respond to the treatment. The oral daily morphine-equivalent dose prior to inclusion was 164 mg. The mean daily epidural start dose of morphine wets 18 mg (range, 6-120), and the mean daily dose at termination was 69 mg (range, 2-540). The dose escalations, described as the ratio of the maximum dose to the minimum maintenance start dose, were moderate, with a mean of 4.1 (median, 2.5), which corresponded to a percent increase of 5.1 (median, 2.7) per patient per day. Lack of effect due to the character of the original symptoms or progression of pain was the main reason for withdrawal from epidural opioid therapy, (N = 27), followed by **catheter**- related problems (N = 9) and drug-related complications (N = 5). Also due to drug-related complications, epidural morphine therapy was changed to buprenorphine or methadone in 19 patients. Adjuvant systemic opioids were given to ten patients and epidural local anesthetics were administered to 17 of the subjects. Neuropathic pain, certain visceral pain types, incident pain on movement, and pain from cutaneous ulceration were characterestics of poor responders. We conclude that epidural morphine therapy can be an effective alternative in the treatment of cancer pain. Lack of therapeutic efficacy due to the specific character of pain and not drug related or **catheter** related complications represented the major reason for treatment withdrawal.

L8 ANSWER 36 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 94137977 EMBASE
DN 1994137977
TI **Intrathecal** morphine and bupivacaine in advanced cancer pain patients implanted at home.
AU Mercadante S.
CS Pain Relief and Palliative Care Unit, SAMOT, via Liberta 191,90143 Palermo, Italy

SO Journal of Pain and Symptom Management, (1994) Vol. 9, No. 3, pp. 201-207.
ISSN: 0885-3924 CODEN: JPSMEU
CY United States
DT Journal; Article
FS 016 Cancer
024 Anesthesiology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 940525
Last Updated on STN: 940525
AB Fifteen patients with pain due to advanced cancer who no longer obtained relief from conventional treatment using oral or parenteral opioids were administered morphine and bupivacaine by continuous **intrathecal** infusion. Thirteen patients were implanted at home due to poor medical condition or refusal to be hospitalized. A summary score was derived to monitor the effects of the treatment. Thirteen patients required low doses of **intrathecal** morphine and bupivacaine and all reported good pain relief until death. Only minor side effects were evidenced. Implantation at home of an **intrathecal catheter** to administer morphine and bupivacaine provided a degree of pain relief during the last days of life that would have otherwise been impossible and did so without producing important complications.

L8 ANSWER 37 OF 39 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 93300837 EMBASE
DN 1993300837
TI Long-term **intrathecal** infusion of morphine and morphine/bupivacaine mixtures in the treatment of cancer pain: A retrospective analysis of 51 cases.
AU Van Dongen R.T.M.; Crul B.J.P.; De Bock M.
CS Inst. Anesthesiology/Pain Treatment, University Hospital Nijmegen, Geert Groote Plein Zuid 10,6500 HB Nijmegen, Netherlands
SO Pain, (1993) Vol. 55, No. 1, pp. 119-123.
ISSN: 0304-3959 CODEN: PAINDB
CY Netherlands
DT Journal; Article
FS 008 Neurology and Neurosurgery
030 Pharmacology
037 Drug Literature Index
LA English
SL English
ED Entered STN: 931114
Last Updated on STN: 931114
AB A retrospective analysis of 51 patients with cancer pain treated with a continuous i.t. morphine infusion through a tunnelled percutaneous **catheter** was undertaken. Because of insufficient pain relief with morphine only, 17 of these patients received a morphine/bupivacaine mixture. Pain releif subsequently improved significantly in 10 patients and a moderate improvement was present in 4 patients. An additional analgesic effect of bipivacaine was not shown in 3 patients with clinical signs of severe mental depression. Bupivacaine-induced side effects were absent below a daily dosage of 30 mg by continuous infusion. In all patients a gradual dose increment was observed. No serious complications, neurologic sequelae or meningitis occurred. It is concluded that long-term i.t. infusion of morphine through a tunnelled **catheter** can provide adequate pain relief in cancer patients with an acceptable risk-benefit ratio. The effects of long-term **intrathecal** co-administration of local anesthetics, especially bupivacaine, await further prospective evaluation.

L8 ANSWER 38 OF 39 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 1992:123190 BIOSIS
DN PREV199293068990; BA93:68990
TI CURRENT METHODS OF CONTROLLING POST-OPERATIVE PAIN.

AU SINATRA R S [Reprint author]
CS DEP ANESTHESIOLOGY, YALE UNIV SCH MED, 333 CEDAR STREET, NEW HAVEN, CONN 06510, USA
SO Yale Journal of Biology and Medicine, (1991) Vol. 64, No. 4, pp. 351-374. CODEN: YJBMAU. ISSN: 0044-0086.
DT Article
FS BA
LA ENGLISH
ED Entered STN: 1 Mar 1992
Last Updated on STN: 1 Mar 1992
AB Until recently, the clinical significance of post-surgical pain and its undertreatment were for the most part unappreciated. Recognition that inadequate analgesia adversely affects the patient's cardiovascular, pulmonary, and emotional status has spurred developed of new and highly effective methods of controlling pain. With the introduction of spinal opioid and patient-controlled analgesia (PCA) came the realization that, while such forms of therapy provided superior pain relief, they were not without their own unique and occasionally serious side effects. For this reason, both techniques are more safely provided by highly trained members of a dedicated acute/post-surgical pain service. Although spinal opioid (epidural, **intrathecal**) techniques are invasive and require patient cooperation, they have a high degree of safety in low-risk populations (ASA 1 and 2). The major therapeutic advantage of spinal opioids is their ability to prevent pain from being perceived. PCA permits patients to titrate intravenous opioids in proportion to their particular level of pain intensity. Although PCA provides effective pain "relief", the technique is incapable of preventing pain from being appreciated. A number of studies have observed that pain scores in patients successfully employing PCA were significantly higher than those noted in individuals treated with epidural opioids. Nevertheless, the control gained by self-administration, uniformity of analgesia, and low level of adverse results associated with PCA provides higher patient satisfaction and decreased sedation when compared with traditional intramuscular dosing. The effectiveness of PCA may be improved by adjusting for patient variables, utilizing opioids having rapid onset, the addition of a basal infusion, and supplementation with non-steroidal **anti-inflammatory** agents. Interpleural analgesia represents an important therapeutic option in patients sensitive to opioid-induced respiratory depression. The technique is more effective when local anesthetic solutions are continually infused. Analgesic efficacy may be further enhanced by addition of "low-dose" PCA.

L8 ANSWER 39 OF 39 BIOSIS COPYRIGHT (c) 2005 The Thomson Corporation on STN
AN 1990:73468 BIOSIS
DN PREV199089041294; BA89:41294
TI THERMAL ANALGESIA FOLLOWING **INTRATHECAL** CAPSAICIN ADMINISTRATION IN RATS DETAILED MEASUREMENTS OF THERMAL ANALGESIA OVER THE LOWER BODY BY A THERMAL PROBE.
AU HARADA Y [Reprint author]; AOKI M; NAMIKI A; SHIMIZU H
CS DEP ANESTHESIOL, SAPPORO MED COLL HOSP, SAPPORO, 060
SO Japanese Journal of Anesthesiology, (1989) Vol. 38, No. 10, pp. 1329-1334. CODEN: MASUAC. ISSN: 0021-4892.
DT Article
FS BA
LA JAPANESE
ED Entered STN: 23 Jan 1990
Last Updated on STN: 24 Jan 1990
AB This study was undertaken to examine the thermal pain thresholds over a wide area of the lower body surface following the **intrathecal** administration of capsaicin in rats. Thermal nociceptive thresholds measured under light halothane anesthesia were determined as skin twitch or escape response latencies to the heat stimulation (52.0° C) by a thermal probe. Capsaicin (50 μg in 10 μl) was injected through a chronically implanted **catheter** whose tip was near the lumbar enlargement of the spinal cord. The hot-plate test (52.0° C) was also performed in all rats tested. Increases in thermal pain thresholds were consistently observed in the low back and abdominal region, while the

hind paws did not always respond with prolonged skin twitch or escape latencies. Intensities of thermal analgesia at the sole of hind paws measured by hot-plate test correlated well with those by thermal probe test. In conclusion, **intrathecal** capsaicin definitely produced thermal analgesia, but its intensity was considerably variable in the hind paws. These results are in keeping with our previous finding that there was much variabilty in the effect of capsaicin assessed by the hot-plate test, indicating a possibility that capsaicin does not spread uniformly in the CSF because of its water insolubility or difficulty in penetrating to the large nerve roots innervating the hind paws.

L10 ANSWER 1 OF 2 CAPLUS COPYRIGHT 2005 ACS on STN
AN 2004:473339 CAPLUS
DN 141:33787
TI A small interfering oligonucleotide duplex inhibiting COX-II isoenzyme without affecting COX-I expression, and methods for treating COX-II associated diseases
IN Shemesh, Mordechai; Shore, Laurence; Stram, Yehuda; Michaeli, Shulamit; Breitbart, Haim
PA Kimron Veterinary Institute, Israel; Bar-Llan University
SO U.S. Pat. Appl. Publ., 30 pp.
CODEN: USXXCO
DT Patent
LA English
FAN.CNT 1

PATENT NO.	KIND	DATE	APPLICATION NO.	DATE
PI US 2004110698	A1	20040610	US 2002-315218	20021210
PRAI US 2002-315218		20021210		

AB The present invention relates to oligonucleotides which can be used to treat COX-II (cyclooxygenase inducible isoenzyme)-associated diseases such as, diabetes, stroke and **Alzheimer**'s disease. The present inventor provided, for the first time, a small interfering oligonucleotide duplex (siRNA), which enables to inhibit COX-II protein production without affecting COX-I expression. A small interfering duplex oligonucleotide comprising a 15 to 30 base pair sequence being at least 90 % identical to a contiguous nucleic acid sequence of COX-II, as determined using the GCG BestFit software of the Wisconsin sequence anal. package, utilizing the Smith and Waterman algorithm, where gap weight equals 50, length weight equals 3, average match equals 10 and average mismatch equals -9.

L10 ANSWER 2 OF 2 EMBASE COPYRIGHT 2005 ELSEVIER INC. ALL RIGHTS RESERVED. on STN
AN 96005155 EMBASE
DN 1996005155
TI Implantable pumps for drug delivery to the brain.
AU Bakhshi S.; North R.B.
CS Meyer 7113, Department of Neurosurgery, John Hopkins Hospital, 600 N. Wolfe St.,Baltimore, MD 21205, United States
SO Journal of Neuro-Oncology, (1995) Vol. 26, No. 2, pp. 133-139.
ISSN: 0167-594X CODEN: JNODD2
CY United States
DT Journal; Article
FS 008 Neurology and Neurosurgery
016 Cancer
027 Biophysics, Bioengineering and Medical Instrumentation
030 Pharmacology
037 Drug Literature Index
038 Adverse Reactions Titles
LA English
SL English
ED Entered STN: 960116
Last Updated on STN: 960116
AB This article reviews the role of implantable pumps in the treatment of CNS tumors. Systemic administration of chemotherapeutic agents has been associated with various problems, including adverse systemic effects and decreased concentration of the drug at the target site. Continuous infusion of chemotherapeutic agents with implantable pumps have been used in an attempt to overcome these problems. Various different chemotherapeutic agents have been used for this purpose, and catheters have been placed in the intraspinal, intraventricular and intratumoral locations.

(FILE 'HOME' ENTERED AT 15:33:09 ON 18 JUL 2005)

FILE 'MEDLINE, BIOSIS, EMBASE, CAPLUS' ENTERED AT 15:33:18 ON 18 JUL 2005

L1	1357	S INTRATHECAL CATHETER?
L2	0	S L1 AND ALZHEIMER?
L3	9	S L1 AND (NSAID OR ((ANTIINFLAMMATORY OR ANTI-INFLAMMATORY) (2W
L4	9	DUP REM L3 (0 DUPLICATES REMOVED)
L5	2831	S INTRATHECAL AND CATHETER
L6	48	S L5 AND (NSAID OR ANTIINFLAMMATORY OR ANTI-INFLAMMATORY)
L7	42	S L6 NOT L4
L8	39	DUP REM L7 (3 DUPLICATES REMOVED)